Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRIDE
5701 MAPLE AVENUE SUITE #100
DALLAS TX 75235

DWC Claim
Injured Employee:
Date of Injury:
Employer Name
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2229

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with the DWC rule 134.600 9 (c)(B) and (p)(B)(10) and insurance carrier is liable for all reasonable and necessary medical costs relating to interdisciplinary pain management, functional restoration, physical/occupational therapy and or counseling when it was pre-authorized prior to providing the care. As can be seen from the attachments the medical care in question was preauthorized at the address the care was provided. Texas Mutual Insurance Company (TMIC) and the Texas Star HCN were aware throughout the entire process (and for 2 years prior to the initial denial of benefits) that PRIDE was a non-network provider of rehabilitation services. Unique electronic billing requirement requested by Texas Star HCN were established for PRIDE services in mid-2008, and used continuously from that time forward. At the time all services were pre-authorized. Dr. Larry Johnson, a PRIDE physician independent contractor, was listed as Requesting Provider. For those reasons the carrier is liable for the medical services that are subject of this request for Dispute Resolution."

Amount in Dispute: $10,789.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided therapeutic excersize, office visit and psychotherapy services to the claimant from 04/21/2010 through 06/17/2010. This claim is in the Texas Star Network ('Network')…The requestor is not a participating health care provider in that network. The treating doctor is Vivian L. Jones, M.D. …DWC 134.600(h) states that the carrier shall approve or deny preauthorization requests based solely upon the medical necessity of the health care required to treat the injury. …Review of Texas mutual's claim file shows (1) the requestor's documented treatment does not reflect treatment one would normally consider as emergency care; (2) the claimant lived within the service area of the network; and (3) there is no documentary evidence of a referral by the treating doctor to the requestor for treatment. …Texas Mutual has no record of any request for a referral from the treating doctor to this out-of –network provider nor has the requestor provided any evidence of such in its DWC-60 packet."

Response Submitted by: Texas Mutual Insurance; 6210 East highway 290; Austin Tx 78723 -1098

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2010 thru June 17, 2010	97530, 99215, 20552, 90806 and 99214	$10,789.68	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS
   - CAC-38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK/PRIMARY CARE) PROVIDERS.
   - 727 PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT FOR NETWORK INFORMATION CALL 800-381-8067
   - CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-W4 NO ADDITIONALREIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
   - 724 NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES FOR INFORMATION CALL 800-381-8067
   - 891 NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 892 DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE
   - 907 ONLY TREATMENT RENDERING FOR THE COMPENSABLE INJURY IS REIMBURSEABLE NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.
   - 434 THIS PROCEDURE CODE IS NOT REIMBURSED WHEN BILLED WITH ANOTHER MUTUALLY EXCLUSIVE PROCEDURE CODE ON THE SAME DATE OF SERVICE
   - 231 (No explanation provided on EOB)

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305 and §133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, division of Workers' Compensation (Division), Medical Fee dispute Resolution section on March 03, 2011 for resolution pursuant to 28 Texas Administrative Code §133.307.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (6) of the same rule as "Health care not delivered,or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Texas Administrative Code §133.307(a)(1) similarly states that "this section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Texas Administrative Code §133.305, and §133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.
3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 6, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.